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September 14, 2006

Rex Redden,
Idaho Falls Group Home #3 (Periska)
950 Periska Way
Idaho Falls, ID 83405

Dear Mr. Redden:

On August 11, 2006, a complaint investigation survey was conducted at Idaho Falls Group Home #3. The survey was conducted by Michael Case, LSW, QMRP and Nicole Wisenor, QMRP. This report outlines the findings of our investigation.

Complaint # ID00001230

Allegation #1: The facility's high staff turn over rates have caused a lack of adequately trained staff which is leading to inconsistent interventions being implemented.

Findings: An on-site investigation was conducted from 8/7/06 - 8/11/06. Observations, record reviews and interviews were completed.

The behavior plans and raw behavior data for 4 individuals were reviewed. The data documented inconsistent interventions being employed in response to the individuals' maladaptive behaviors, which were not in accordance with their behavior plans.

Further, during an observation conducted on 8/8/06 at 4:15 p.m., an individual was observed engaging in maladaptive behaviors. The staff was not observed to implemented interventions as specified in her behavior plan. The Home Supervisor intervened and provided training to the staff. However, the training that was provided to the staff was not consistent with the individual's behavior plan.

When asked about the inconsistent interventions, on 8/10/06 at 4:33 p.m., the QMRP stated it was a staff training issue. When asked about staff turn over, the AQMRP stated on 8/10/06 at 4:58 p.m., that the facility had experienced changes in management staff and direct care staff over the past several months.

Conclusion: The facility had experienced high turn over rates of direct care staff, multiple changes in Home Management staff, and a change of QMRPs. The staffing issues contributed to the facility's difficulties in on-going training, which resulted in inconsistent interventions being implemented. Therefore, the allegation is substantiated and deficient practices were identified.

Allegation #2: Individiuals are not being provided sufficient opportunities to participate in community activities.

Findings: An on-site investigation was conducted from 8/7/06 - 8/11/06. Observations, record reviews and interviews were completed.

1. The individuals' community integration logs from 1/1/06 - 7/31/06 were reviewed. The logs documented the individuals were not participating in sufficient numbers of community integration activities. When asked about the facility's staffing patterns, on 8/10/06 at 10:55 a.m., staff stated they were to have 4 staff on the a.m. and p.m. shifts and that there was also a community recreation person who was designated to take the individuals into the community. The facility's as work schedules documented the facility was without a community recreation staff as follows:

1/06:
1/1 - 1/9, 1/12 - 1/18, and 1/20 - 1/31. Of the 31 days in 1/06, the community recreation staff was only available 3 days.

2/06:
2/1 - 2/22 and 2/24 - 2/28. Of the 38 days in 2/06, the community recreation staff was only available 1 day.

3/06:
3/1 - 3/31. The community recreation staff was not available in 3/06.

4/06:
4/1 - 4/20, 4/23 - 4/25, and 4/28 - 4/30. Of the 30 days in 4/06, the community recreation staff was only available 4 days.

5/06:
5/1, 5/7 - 5/8, 5/14 - 5/15, and 5/21 - 5/31. Additionally, the community recreation staff was assigned to work direct care on 5/19 and 5/20, and therefore unavailable to take the individuals on community outings. Of the 31 days in 5/06, the community recreation staff was only available 13 days.

6/06:
6/4 - 6/5, 6/11 - 6/12, 6/18 - 6/19, and 6/25 - 6/26. Additionally, the community recreation staff was assigned to work direct care on 6/16, 6/17, 6/20, 6/24, 6/27, and 6/30, and therefore unavailable to take the individuals on community outings. Of the 30 days in 6/06, the community recreation staff was only available 11 days.

7/06:
7/2 - 7/3, 7/9 - 7/10, 7/16 - 7/17, 7/23 - 7/24, 7/30 - 7/31. Additionally, the community recreation staff was assigned to work direct care for half a shift on 7/8 and 7/22, and for full shifts on 7/15, 7/28, and 7/29, and therefore unavailable to take the individuals on community outings. Of the 31 days in 7/06, the community recreation staff was only available 18 days.

During interview on 8/10/06 at 2:51 p.m., the AQMRP stated the facility did not have a community outing staff in March 2006. The AQMRP stated a staff was hired to run community outings, but the staff did not have a drivers license which prevented her from taking individuals into the community. The AQMRP stated the issue was resolved in the middle of May 2006. However, the AQMRP also stated that the community utilization staff was being pulled to work direct care due to the facility being short staffed.

Conclusion: The facility failed to provide sufficient staff to ensure individuals were afforded sufficient opportunities to participate in community outings. Therefore, the allegation is substantiated and deficient practices were identified.

Allegation #3: The individuals legal guardians are not being kept informed of significant events.

Findings: An on-site investigation was conducted from 8/7/06 - 8/11/06. Observations, record reviews and interviews were completed.

The incident reports, behavior logs, and parent/guardian notification forms were reviewed. The facility did not notify the guardians of significant events for 2 of the individuals as follows:

a. An individual's "Parent/Guardian Contact List," dated 2/9/06, listed incidents that the individual's guardians wanted to be informed of. The incidents included client to client contact with or without injury and routine illnesses. The individual's injury and illness reports documented he had experienced the following:

- On 10/19/05 at 8:10 a.m. he was experiencing a cough and congestion. Documentation that his guardians had been notified of the illness could not be found in his record.

- On 5/2/06 at 8:00 p.m. he vomited. Documentation that his guardians had been notified of the illness could not be found in his record.

Additionally, his ABC data sheets documented the following:

- On 5/1/06 at 7:00 (a.m. or p.m. not indicated), staff came out of another individual's room and saw the individual hitting another individual.

- On 6/6/06 at 8:55 p.m. the individual climbed into bed with a second individual. The second individual woke up and asked the individual to leave. He refused to leave and the second individual tried to push him out of the bed. He began to punch the second individual and the second individual left the room and told the staff "Dude, (###) you need to keep an eye on your client" and asked for the staff's assistance to keep the individual out of his room. Staff went into the bedroom room and the individual was no longer there. Staff then found the individual in another individual's bed. Staff then asked him to go to his own bed, which he did.

Documentation that the individual's guardians had been notified of the above mentioned incidents could not be found. When asked about the notification, the AQMRP stated, on 8/10/06 at 5:00 p.m., that if the guardians had been notified it would be documented on an incident report.

b. Another individual's parent/guardian contact list, dated 2/18/06, stated her parents wanted to be notified if she experienced any small scrapes or bruise or minor injury of any kind, large bruise or injury that needs bandaging, and any unusual developments (i.e. unknown lumps or swelling, skin conditions, etc.).

The individual's incident/accident reports from 12/05 - 8/8/06 were reviewed. The record did not include documentation that her parents had been notified of all injures of unknown origin as follows:

a. An incident report, dated 6/17/06 at 2:00 p.m., stated she had a bruise of unknown origin on her abdomen.

b. An incident report, dated 7/16/06 at 1:00 a.m., stated she had discoloration of her right ankle, origins unknown.

When asked on 8/10/06 at 5:00 p.m., about notification of the incidents, the AQMRP stated if the parents were notified it would be documented on an incident report.

Conclusion: The facility did not consistently inform the individuals' guardians of the individuals' significant events. Therefore, the allegation is substantiated and deficient practices were identified.

Allegation #4: The activities in the home are not age appropriate.

Findings: An on-site investigation was conducted from 8/7/06 - 8/11/06. Observations, record reviews, and interviews were completed.

Conclusion: The age range of the individuals residing at the facility was 10 to 55 years of age. During observations conducted on 8/7/06 and 8/8/06, and during an environment review conducted on 8/10/06, it was noted there were a variety of materials and activities available to the individuals some of which were observed to be used. For example skateboards, bicycles, scooters, balls and video games were available for the younger individuals and western videos, magazines, balls, and board games were available for the older individuals. Therefore, the allegation is unsubstantiated.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208)334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

NICOLE WISENOR
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

NW/mlw